This form must be received by the Benefits Department within 31 calendar days of the mid-year election change event.

Press Tab to begin filling out the form.

SF 4400-DIS # (3-2002)
Supersedes (4-2001) issue

Sandia National Laboratories

Medical Insurance Dependent Disenrollment Form

PLEASE PRINT CLEARLY

A) Medical Plan Information

Please select the plan you would like to be enrolled under or the plan that you are currently enrolled in:

☐ Top ☐ Intermediate ☐ **Basic** ☐ **CIGNA**

B) Primary member information:

I am a(n): *(check one)* ☐ **Employee or Student employee** ☐ **Retiree** ☐ **Surviving Spouse** ☐ **COBRA participant**

Last Name | First Name | Middle Initial | Date of Birth | Social Security Number

Street Address | City, State *(Please abbreviate)* | Zip Code

Union Affiliation *(check one)* ☐ None ☐ OPEIU ☐ MTC ☐ SPA

Home Phone | Work Phone

C) Disenrollment Information:

Please list below each dependent to be disenrolled.

Last Name, First Name	Date of Birth	Reason for disenrollment: (mid-year election change event)	Date of Change	**For Benefits Use Only: Disenrollment Date**

D) Please sign below to authorize the disenrollment of the above dependent(s) from your medical insurance plan.

Employee Signature | **Date**

Benefits Employee Signature | **Date Received**

This form must be received by the Benefits Customer Service Center, MS 1022, within 31 days of the mid-year election change event if your premiums are deducted on a pre-tax basis.

For Benefits Use Only:

PS: _____ /Rx: _____